WMAP Provider Handbook, Part D, Division II Issue: 02/95

APPENDIX 4c HEALTHCHECK SERVICE CODES TARGETED OUTREACH SCREENING PROVIDED BY ANOTHER PROVIDER CLAIM SORT INDICATOR 'P' RECEIVED BY THE FISCAL AGENT ON OR AFTER 2 /15/ 95

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1 MEDICARE MED (Medicare #) P (Med		AMPUS onsor's S		CHAMPVA (VA File #)	(SSN	TH PLAN BL or ID) (CA OTHER K LUNG SSN) (ID)	12345	S I.D. NUME 67890	ER		(FOR P	ROGRAMI	N ITEM 1)	
2 PATIENT'S NAME (Last) Recipient.		Middle	Initial)		PATIENTS MM DI		SEX F	4. INSURED'S	NAME (Las	t Name. Fil	st Name	. Middle	Initial)		
5 PATIENT'S ADDRESS (N						ELATIONSHIP T		7. INSURED'S	ADDRESS	(No., Stree	t)			·	
609 Willow	St.			STATE 8	Self S	pouse Chik	Other	CITY					I e	TATE	
Anytown					Single	Married	SIAIE								
IP CODE TELEPHONE (Include Area Code)					Employed -		ZIP CODE TELEPHONE (INCLUDE AREA CODE)						(CODE)		
55555 (XXX) XXX-XXXX OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						Student IT'S CONDITION	Part-Time Student	11. INSURED'S POLICY GROUP OR FECA NUMBER							
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a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYME	NT? (CURREN	a. INSURED S DATE OF BIRTH MM DD YY M F								
DOTHER INSURED'S DATE OF BIRTH SEX					. AUTO ACCI	DENT?	D. EMPLOYER'S NAME OR SCHOOL NAME								
EMPLOYER'S NAME OR SCHOOL NAME					OTHER ACC	YES	c. INSURANCE PLAN NAME OR PROGRAM NAME								
d INSURANCE PLAN NAME OR PROGRAM NAME					Od. RESERVE	ED FOR LOCAL	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?								
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE authorize the release of any medical or other information necessary								13. INSURED		ORIZED PI	ERSON'S	SIGNA		horize	
to process this claim. I als below									medical ber escribed belo		undersiç	gned phy	ysician or su	pplier for	
SIGNED DATE									SIGNED						
					PATIENT HAS VE FIRST DAT	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN								18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO							
19 RESERVED FOR LOCAL USE								20. OUTSIDE LAB? \$ CHARGES							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)								22. MEDICAID RESUBMISSION ORIGINAL REF. NO.							
, <u>V70</u> <u>0</u>					3			23. PRIOR AUTHORIZATION NUMBER							
2 <u> </u>		I B	Гс	4.	<u></u>) E	F	1 1 7	<u>а Гн</u>		J			
DATE(S) OF SEF From MM DD YY MN		Place of	Type of Service		Unusual Circu		DIAGNOSIS CODE	\$ CHARG	ES 0	YS EPSD OR Famil IITS Plan	Y ENG	СОВ		ED FOR	
3 25 95		3	1	W7012	2		1	XX	xx	1					
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				i.		\$. #								•	
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 1234JD YES NO								28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ XX XX \$ \$ \$ XX XX							
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Authorized MM/DD/YY								33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE 8 PHONE # I. M. Billing							
.M. Authoriz	ed MM/DD/Y	Y						1 W.	W1111e	ıms					
IGNED DATE								Anytown, WT 55555							